STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155766	A. BUILDING 00 B. WING	06/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE MANOR CHRISTIAN HOME INC	643 WEST UTICA ST SELLERSBURG, IN47172

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: June 20, 21, 22, 23, 2011 Facility number: 000563 Provider number: 155766 Aim number: 100267610 Survey team: Avona Connell, RN TC Donna Groan, RN Dorothy Navetta, RN Gloria Reisert, MSW Census bed type: SNF/NF: 51 Total: 51 Census payor type: Medicare: 02 Medicaid: 34 Other: 15 Total: 51 Sample: 13 Supplemental sample: 19 These deficiencies also reflect State Findings cited in accordance with 410 IAC 16.2 .	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Quality review completed 6/27/11 Cathy Emswiller RN			

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F0157 SS=D	A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on record review and interview, the facility failed to notify the responsible party and physician when 1 of 2 residents reviewed for changes in condition in a sample of 13 residents was found with blood in/around the mouth and facial area on 2 occasions (Resident #12); and failed to notify the physician when a	F0157	Res#12 - There have been no other noted incidents of resident having mouth bleeding. This resident was also seen by the dentist on 7/5/11 as routine visit with no new orders given at that time.Res#34 - Mammogram has been completed with results received - no mammographic evidence of malignancy.	07/22/2011

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	mammogram (a test to detect possible cancer in the breast) was not completed as ordered for 1 of 1 resident reviewed for mammogram orders in a sample of 13 residents (Resident #34). Finding includes: 1. Review of the clinical record for Resident #12 on 6/20/2011 at 10:25 a.m., indicated the resident had diagnoses which included, but were not limited to, anemia, aortic stenosis, history of gastrointestinal bleed, and hypertension. Nursing notes between 3/22/2011 and 5/20/2011 included the following entries: - "4/17/11 - 0145 [1:45 a.m.]: Dried blood observed on corners of mouth, lips and coating tongue. Mouth cleansed. This writer unable to locate source of bleeding. Will continue to monitor. Bleeding appears to have subsided." - "4/19/11 - (no time listed): Nurse entered room early this morning to administer 0600 medication and noticed moderate amount of dry, dark blood on mouth, down the neck, on the pillow. Denies pain or discomfort." Documentation was lacking of the physician and responsible party having been notified of the 2 episodes of		Screening mammogram in 1 year recommended.Nurses notes and orders are being reviewed on all residents. If any issues are found the Medical Record Supervisor/Designee will make appropriate corrections, ie: schedule appointments, call physician, call responsible party, etc. with documentation of corrections.All orders for diagnostic test or appointments will be given to Medical Record Supervisor for follow up daily to ensure completion. Nurses notes will be read daily by Medical Record Supervisor/Designee, on regular scheduled days to work, to ensure complete. Inservice held with nurses on 7/12/11 to include review of Policy and Procedure for Notification of Changes. (see attached) Pertinent Charting Guidelines have been developed and were explained in the inservice with acknowledgement forms signed. (see attached) Any nurse that was not able to attend will be given the information prior to completion date. The attached QA sheet will be utilized by the Medical Record Supervisor/Designee on regular scheduled days. This will be an ongoing process.	

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	bleeding. During an interview with the Director of Nursing on 6/22/2011 at 8:45 a.m., she indicated the physician and family should have been notified of the bleeding for possible new orders. 2. The clinical record for Resident #34 was reviewed on 06/22/11 at 9:35 a.m. The resident diagnoses included, but were not limited to; history of breast cancer. The resident was admitted to the facility on 02/22/11. A Physician Order signed and dated 06/01/11 "Mammogram at (name of place to have Mammogram) diagnosis breast ca (cancer)" In interview with Licensed Practical Nurse #1, at 11:00 a.m., on 06/22/11, she indicated she was unable to determine, if the Mammogram had been scheduled. In interview with the resident on 06/22/11 at 2:00 p.m., she indicated she had not had a Mammogram since admission to the facility. Nursing notes failed to indicate the Mammogram had been scheduled or the physician had been made aware the test had not been completed as ordered. On 6/23/2011 at 9:00 a.m., the DoN presented a copy of the facility's current policy on "Resident Rights/ Notification			

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	of Changes". Review of this policy at this time, included, but was not limited to: "Policy:...It is the intent of the facility to inform the resident; consult with the resident's physician, and if known, notify the resident's...interested family member if there is a significant change in the resident's physical....status...It is he intent of the facility to inform the resident, consult with the resident's physician if there is a need to alter treatment significantly(i.e.,...to commence a new form of treatment) 3.1-5(a)(2) 3.1-5(a)(3)			
F0250 SS=D	The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on record review and interview, the facility failed to ensure the psychiatric order to administer a Geriatric Depression Scale assessment was completed in a timely manner for 1 of 13 residents reviewed for social service interventions in a sample of 13 residents. (Resident #27)	F0250	This asessment has been completed, therefore there is no further action that can be taken.The Medical Record Supervisor keeps copies of all Pharmacist Recommendations. These have been reviewed from the last visit and found to be complete.The Medical Record Supervisor will continue to keep and monitor for completion of	07/22/2011

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	Finding includes: Review of the clinical record for Resident #27 on 6/20/2011 at 1:50 p.m., indicated the resident was admitted to the facility on 6/21/2010 and had diagnoses which included, but were not limited to, dementia, depressive disorder, history of delusions and anxiety. On 5/27/2011, the consultant pharmacist visited and made a recommendation to evaluate the resident's use of Seroquel (an anti-psychotic for history of delusions]. On 6/9/2011, the recommendation was received by the facility and faxed to the resident's psychiatrist who wrote an order on 6/15/2011 to discontinue the Seroquel and administer a Geriatric Depression scale of choice. On 6/16/2011, a call was placed to the psychiatrist to clarify the order as Social Worker #1 indicated on 6/22/2011 at 10:50 a.m., she was unable to read her writing. A note on the bottom of the consultant pharmacist's recommendation indicated that on 6/20/2011, Social Worker #1 spoke with the psychiatric nurse, who reported that the psychiatrist wanted a		Pharmacist Recommendations. The D.O.N. has spoken with the Pharmacist and it was decided that the Pharmacist will e-mail all recommendations to the D.O.N. on the night following the visit. The process of faxing to the appropriate physicians will continue. However, if a response is not obtained within a week, the Medical Director or Nurse Practitioner will be contacted for review.The attached QA form will be utilized by the Medical Record Supervisor monthly for all pharmacy recommendations. This will be an ongoing process.	

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	Geriatric Depression scale of facility choice administered. On 6/22/2011 at 1:30 p.m., Social Worker #1 presented a copy of a Geriatric Depression scale she had just completed that day. When queried as to the reason there was a time delay between the order and the completion of the scale report - 27 days - she indicated she was busy "running around getting things for the survey". The order date was 5/27/2011 and the first day of the survey was 6/20/2011. On 6/22/2011 at 1:00 p.m., the medical records clerk presented a copy of Social Worker #1's signed "Job Description". Review of this job description at this time included, but was not limited to, :...Duties:...7. Participate in...development and implementation of social care plans and assessments..." 3.1-34(a)			

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F0279 SS=D	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on record review and interview the facility failed to ensure the dietary care plan was revised when there was a change of condition related to weight loss for 1 of 1 resident in a supplemental sample of 4. (Resident #21) Findings include: The clinical record for resident #21 was reviewed on 6/21/11 at 9:50 a.m. The resident's diagnoses included, but were not limited to; Parkinson's disease and senile dementia. The Care Plan Checklist for Dietary dated 8/6/10 indicated the following: Current diet order Regular NTL (Nectar Thick Liquids), monthly	F0279	The Dietician has updated this careplan, no further action to be done at this time. (see attached)Dietary Manager and Dietician are reviewing careplans of all residents to ensure they are current. If any are found to not be current they will make appropriate updates.Dietary Manager will be responsible for ensuring dietary care plans are updated with each new or changed order. Any new or changed orders will be placed on a diet order form (see attached) and given to the Dietary Manager. Inservice on 7/12/11 included reinforcing need of this form being completed and forwarded to Dietary Manager with each new or changed order that pertains to nutrition/hydration. (see inservice agenda)The	07/22/2011

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	weights, Resident will have stable weight: 239 +/- 5 #. A Care Plan Meeting was held on 4/27/11 with the goal date of 8/20/11. The Weight Record indicated the following: 3/8/11 225.4, 4/7/11 213.7, 5/10/11 207.9, and 6/9/11 193.5. On 6/10/11 a Nutrition Services Recommendation included, but was not limited to: Wt loss down 14 # [pounds] 30 days, Puree diet 5/2511 Unhappy with diet. shakes with Med Pass BID (two times a day), Rec [recommend] Megace ES [extra strength] 1 tsp (teaspoon) QD (every day) for appetite. Weekly wts and NAR (Nutritional at Risk). The above had not been added to the care plan. Documentation was lacking of the Care Plan being updated to reflect the resident's current status. On 6/22/11 at 8:55 a.m., in interview with LPN #1, she indicated the Registered Dietician had just come in and updated the Care Plan Checklist which included, but was not limited to: Current Diet Order 5/25/10 Puree diet, Actual Significant Weight Loss of 7 % in 30 days 6/22/11, Supplement: Shakes TID (three times a day), appetite stimulant: megace 6/15/11, Provide assist at meals: as needed 6/22/11, Weekly weight, and NAR monitoring.		attached QA form will be utilized by the Dietary Manager. The Dietician will review for accuracy with each visit. This will be an ongoing process.	

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	3.1-35(a) 3.1-35(b)(1)			
F0280 SS=D	The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Based on record review and interview, the facility failed to ensure the care plan was updated with revised interventions when a resident returned from the orthopedic surgeon following an evaluation of her dislocated shoulders. The resident required special care of shoulder movements when being transferred or assisted to stand. This deficient practice affected 1 of 1 resident reviewed for orthopedic recommendations in a sample	F0280	This careplan has been updated by the MDS Coordinator, no further action to be done at this time. (see attached)All resident charts will be reviewed for visits to specialists for any information that should be careplanned. Careplans will be updated accordingly.Progress notes and orders will be reviewed when residents return from going out to appointments with specialists, tests, etc or when specialist visit the building. Careplans will be	07/22/2011

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	of 19 residents. (Resident #27) Finding includes: Review of the clinical record for Resident #27 on 6/20/2011 at 1:50 p.m., indicated the resident was admitted to the facility on 6/21/2010 and had diagnoses which included, but were not limited to, arthritis, dementia and status post dislocated bilateral shoulders. On 7/7/2010, care plans were written for: 1. "ADL [Activities of Daily Living] Maintenance/Rehab/Restorative-Mobility Supervised: [name of resident] is at risk for a decline in her joint mobility d/t [due to] general weakness, inactivity, and poor motivation". 2. ADL [Activities of Daily Living] Maintenance/Rehab/Restorative-Transfers Limited assist: [name of resident] is at risk for a decline in her ability to transfer d/t weakness and inactivity," These care plans were updated on 3/19/2011. On 5/17/2011, the orthopedic surgeon evaluated the resident after an X-ray indicated she may have bilateral shoulder dislocations and made the following recommendations: "use caution when		updated as appropriate by Medical Record Supervisor or Designee.The attached QA sheet will be utilized to monitor the above. This will be an ongoing process.	

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	lifting [name of resident] due to dislocated shoulders. Don't pull on arms, lift under arm pits when she needs assistance." Documentation was lacking of the care plans having been updated to reflect the new recommendations by the orthopedic surgeon. Upon interview during the daily exit meeting on 6/21/2011 at 3:10 p.m., LPN #1 indicated each discipline was responsible for updating their own care plans and then when the interdisciplinary team met, everyone will discuss and make any other changes/updates. During an interview with the Director of Nursing on 6/22/2011 at 8:45 a.m., she indicated the care plans should have been updated to reflect the orthopedic surgeon's special instructions for transfers. 3.1-35(d)(1) 3.1-35(d)(2)(A) 3.1-35(d)(2)(B)			
F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.			

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	Based on record review and interview, the facility failed to ensure physician orders were followed for a Mammogram for 1 of 1 resident in a supplemental sample of 19 reviewed with orders for a Mammogram. (Resident #34) Findings include: 1. The clinical record for Resident #34 was reviewed on 06/22/11 at 9:35 a.m. The resident diagnoses included, but were not limited to; history of breast cancer. The resident was admitted to the facility on 02/22/11. A Physician Order dated 06/01/11 "Mammogram at (name of place to have Mammogram) diagnosis breast ca (cancer)" The record lacked results of the mammogram when reviewed on 06/22/11. In interview with Licensed Practical Nurse #1, at 11:00 a.m., on 06/22/11, she indicated she was unable to determine, if the Mammogram had been scheduled. In interview with the resident on 06/22/11 at 2:00 p.m., she indicated she had not had a Mammogram since admission to the facility. Nursing notes failed to indicate the Mammogram had been scheduled or that the physician had been made aware the test had not been completed as ordered.	F0282	Mammogram has been completed with results received - no mammographic evidence of malignancy - screen mammogram in 1 year recommended.Nurses notes and orders are being reviewed on all residents. If any issues are found the Medical Record Supervisor or Designee will make appropriate corrections, ie: schedule appointments, call physician, call responsible party, etc. with documentation of corrections.all orders for diagnostic tests will be given to Medical Records Supervisor for follow up daily to ensure completion. Pertinent Charting Guidelines have been developed and were explained in the inservice with acknowledgement forms signed. (see attached) Any nurse that was not able to attend will be given the information prior to completion date.The attached QA sheet will be utilized by the Medical Records Supervisor/Designee with each diagnostic test. This will be an ongoing process.	07/22/2011

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	In interview with the Director of Nursing (DON) on 06/23/11 at 8:37 a.m., she indicated the Mammogram was now scheduled for June 28th, at 10:15 a.m. She further indicated it was not scheduled until she was made aware of the physician order at the daily exit on 06/22/11 at 3:45 p.m. 3.1-35(g)(2)			
F0309 SS=D	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. A. Based on record review and interview, the facility failed to assess a resident for causes/source of bleeding when 1 of 2 residents was found with blood in/around the mouth and facial area on 2 occasions. This deficient practice affected 1 of 13 residents reviewed for changes in condition in a sample of 13 residents. (Resident #12) B. Based on record review and interview	F0309	Res #12 - There have been no other noted incidents of resident having mouth bleeding. This resident was also seen by the dentist on 7/5/11 as routine visit with no new orders given at that time.Res # 38 - Resident has not displayed any adverse effects from being lowered to floor and has voiced no other complaints of pain to that area. Range of Motion is normal. No further action can be taken at this time.Nurses notes are being	07/22/2011

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	the facility failed to adequately assess the resident status after an assisted fall for 1 of 5 residents reviewed for falls in a sample of 13. (Resident # 38) Findings include: A. Review of the clinical record for Resident #12 on 6/20/2011 at 10:25 a.m., indicated the resident had diagnoses which included, but were not limited to, anemia, aortic stenosis, history of gastrointestinal bleed, and hypertension. Nursing notes between 3/22/2011 and 5/20/2011 included the following entries: - "4/17/11 - 0145 [1:45 a.m.]: Dried blood observed on corners of mouth, lips and coating tongue. Mouth cleansed. This writer unable to locate source of bleeding. Will continue to monitor. Bleeding appears to have subsided." - "4/19/11 - (no time listed): Nurse entered room early this morning to administer 0600 medication and noticed moderate amount of dry, dark blood on mouth, down the neck, on the pillow. Denies pain or discomfort." Documentation was lacking of an assessment on 4/19/2011 to determine		reviewed on all residents. If any issues are found the Medical Record Supervisor or Designee will make appropriate corrections, ie: schedule appointments, call physician, call responsible party, etc. with documentation of corrections.Charts of residents that have fallen since June 1, 2011 will be reviewed for appropriate assessment documentation. If documentation found to not be appropriate the nurse will be instructed on what was incorrect with the documentation.Nurses notes will be read daily by Medical Record Supervisor or Designee to ensure complete. Inservice held with nurses on 7/12/11 to include review of Policy and Procedure for Notification of Changes. (see attached) Pertinent Charting Guidelines have been developed and were explained in the inservice with acknowledgement form signed. (see attached) Any nurse that was not able to attend will be given the information prior to completion date.Unit Manager/Designee will read nurses notes daily (normal schedule to work) after each fall to ensure complete and appropriate. The inservice on 7/12/11 included reinforcing/redistributing the Fall Policy and Procedure, Guidelines for Falls and Fall Assessment. (see attached)The attached QA sheet will be utilized by the Medical Records Supervisor	

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	where the blood had come from. During an interview with the Director of Nursing on 6/22/2011 at 8:45 a.m., she indicated the resident should have been assessed to find the cause and source of the bleeding on 4/19/2011. B. The clinical record for Resident #38 was reviewed on 6/21/11 at 9:45 a.m. The resident's diagnoses included, but were not limited to: dementia and hypertension. Nurse's Notes included, but were not limited to: "5/27/2011 6:00 p.m. CNA alerted this nurse resident was involved in assisted fall. Res reported to have released safety bars and positioned arms inside of lift. Res began to lower to ground as CNA assisted her No redened (sic) bruised areas. CNA denies resident hitting head. Res with complaints of hips hurting while sitting at 90 degrees. ROM (range of motion) WNL (within normal limits)... Family notified. Resident assisted to bed X 3 staff members. Will continue to monitor." Certified Nurses Aide (CNA) On 6/23/2011 at 8:40 a.m., the Administrator provided the facility's		or Designee on regular scheduled days. This will be an ongoing process.Unit Manager/Designee will continue to review each fall by utilizing the attached QA sheet. This will be an ongoing process.	

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	FALL POLICY AND PROCEDURE which included, but was not limited to; Procedure: section # 8, "each time a resident falls they will be assessed immediately (per the established assessment guidelines) by the nurse and before moving the resident another nurse will assess for appropriateness of moving." According to procedure section # 9 "an incident report will be completed by the nurse after assessing the resident." Included was the FALL ASSESSMENT GUIDELINES POLICY AND PROCEDURE which indicated, but was not limited to; "it is the policy of this facility to thoroughly assess a resident for injuries, following a fall, prior to attempting to move or relocate them." According to the procedure section; # 3) suspect a fracture if: E.) the body part hurts if resident attempts to move. (As previously indicated Resident # 38 complained of hips hurting while sitting at 90 degrees.) 4.) if a fracture is suspected: A.) do not move the resident-wait for the ambulance to arrive. (Nursing notes indicate resident was placed in bed with assistance of 3 staff members) E.) check for any vascular or neurological impairment distal to the injury. F.) obtain full set of vitals unless blood pressure is contraindicated due to suspected injury. (Record review indicates documentation is lacking in regards to			

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	vitals or vascular checks 5.) notify physician, family ambulance and DON. (Record review indicated that family had been notified, but lacked documentation that the physician or DON was notified.) 6.) if a fracture is not suspected: A.) call for another nurse to assess resident before moving them. C.) obtain full set of vital signs including orthostatic b/p's (blood pressure's) (Record review indicates documentation is lacking in regards to vitals or a second nurse assessment.) 7.) notify physician and family. (Record review indicated that family had been notified, but lacked documentation that the physician had been notified). 8.) complete incident report and any skin condition reports. (Record review indicates documentation was lacking in regards to "complete incident report".) 6/21/11 at 9:45 a.m. Record review indicated that documentation was lacking that a complete assessment had been performed prior to moving the resident. In interview with the DON on 6/22/11 at 3 p.m. she indicated that she could not find paperwork related to the assisted fall. 3.1-37(a)			

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F0323 SS=D	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to ensure a floor mat alarm identified as a safety intervention after a fall was functional to alert staff when rising for 1 of 5 residents reviewed for falls in a sample of 13 residents. (Resident #21) This deficient practice had the potential to effect 22 residents identified as utilizing an alarming pressure pad. (Residents #12, 26, 30, 21, 36, 38, 23, 31, 32, 37, 44, 43, 29, 28, 53, 19, 18, 13, 7, 5, 1, 16) Findings include: The clinical record for Resident #21 was reviewed on 6/21/11 at 9:50 a.m. The resident's diagnoses included, but were not limited to Parkinson disease and senile dementia. Nurse's Notes included, but were not limited to: 5/21/11 12 a.m. "Res (resident) was found on floor next to bed by CNA (Certified Nursing Assistant). Res stated he was trying to get into his bed and fell backwards. res (sic) hit arm on his trash can and received a bruise and skin tear to L (left) arm...." On 6/22/11 at 11 a.m., the Director of Nursing indicated the alarm didn't sound and the box was changed out. Review of the May 2011 Treatment Record included, but was not limited to: "Sensor pad alarm while up in chair in room; check placement and function every shift" May 21 was initialed as placement and function. The April 2011 Treatment Record indicated the Sensor Pad Alarm had been placed since 6/9/10. The Care Plan Problem At Risk for falls (no date)	F0323	Alarm has been replaced and there has been no further noted issues.All alarm pads will be checked for dates, if no dates are on pad it will be replaced. If there is a date and it is not within the warranty range it will be replaced.All alarm pads will be marked with start date and end date. Unit Manager or Designee will track these dates and replace them as these dates warrant or earlier if found to have an issue.The attached QA sheet will be utilized by the Unit Manager/Designee and it will be an ongoing process.	07/22/2011

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	5/21/11 approach Encourage Res to use call light was added. Sensor pad alarm in chair in room and wheelchair dated 6/9/10. The CNA Worksheet for the 200 hall indicated the resident was a "Fall risk sensor alarm all times." On 6/23/11 at 11 a.m., the Director of Medical Records, provided a list of 21 residents currently utilizing a sensor pad alarm. Residents #12, 26, 30, 21, 36, 38, 23, 31, 32, 37, 44, 43, 29, 28, 53, 19, 18, 13, 7, 5, 1, 16) 3.1-45(a)(1)			
F0514 SS=D	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview the facility failed to ensure records were complete and readily accessible for 1 of 1 resident being followed by the Cancer Care Center in a sample of 13. (Resident # 36) Findings include:	F0514	Copies of progress notes from Cancer Care Center have been received and placed in chart.Calendars that have scheduled appointments listed in them at nurses stations will be reviewed. Charts of those residents that have had appointments since 6/1/11 will be reviewed to ensure progress notes are present. If not, calls will	07/22/2011

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	The clinical record for Resident #36 was reviewed on 6/20/11 at 10:30 a.m. The resident's diagnoses included, but were not limited to: diabetes mellitus and lung cancer. On 6/20/2011 at 10:30 a.m. record review of Physician notes from 4/27/2011 at 3:00 p.m. indicated that Resident # 36 had a new diagnoses of lung cancer and that a positron emission tomography scan (PET) will be scheduled and treatment options will be discussed after results are known. PET was completed on 5/5/2011. Record review indicated the family picked Resident # 36 up at facility and took her to the Cancer Care Center on 5/18/2001 and again on 5/23/2011. Documentation of progress notes from the cancer care center visits and/or nursing notes were lacking upon return with regards for further treatment options. On 6/20/2011 at 1:00 p.m. in interview with the Social Worker, she did not know status of the residents treatment plans. On 6/20/2011 at 2:00 p.m. in interview with Licensed Practical Nurse (LPN) #1 caring for resident # 36 she indicated "they went to oncology and they discussed with the family and family does not want to seek options".		be placed to obtain the information.The Medical Record Supervisor/ Designee will review charts following appointments to ensure progress notes were received, it not, then call will be placed to obtain the information.The attached QA sheet will be utilized to track this information. This will be an ongoing process.	

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	On 6/23/2011 at 9:30 a.m., the Director of Nursing (DON) presented progress notes received dated 6/22/2011 4:04 p.m. via facsimile from the Cancer Care Center (CCC). According to documentation in the progress notes from the CCC indicate "the patient and Power of Attorney for medical decisions decided they want to wait three months. We will see the patient back in three months with another PET." 3.1-50(a)(2)			